TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of SW Fort Worth

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-1021-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.403 section E all HCPC's that are paid per the fee schedule should pay per the APC allowable at 200% regardless of the billed charges… We realize these CT Scans have a Q3 status but they are not bundled per the NCCI edits and still should have had a reduced payment."

Amount in Dispute: $680.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The procedures in dispute are 70450, CT, Head or Brain: Without Contrast and CT Thorax; With Contrast. We have attached a copy of the analysis provided through the CCE pricing tool. These procedures are considered packaged into APC rates."

Response submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2016	70450, 71260	$680.72	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered

- Z710 – The charge for this procedure exceeds the fee schedule allowance
- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- MP86 – Recommended reimbursement is based on CMS Hospital Outpatient Composite APC 8006
- MOPS – Services reduced to the outpatient perspective payment system
- 193 – CPT or HCPC is required to determine if services are payable
- W3 – CPT or HCPC is required to determine if services

Issues

1. What is the applicable rule that pertains to reimbursement?
2. How is the fee calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement of $680.72 for outpatient hospital services rendered on April 1, 2016.

   The insurance carrier reduced the disputed codes 70450 and 71260 as MP86 – "Recommended reimbursement is based on CMS Hospital Outpatient Composite APC 8006."

   28 Texas Administrative Code §134.403 (d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

   The applicable Medicare payment policy as stated in the Medicare Claims Processing Manual, Chapter 4, Section, 10.2.1 states,

   > *Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a* ***single payment for all of the codes as a whole****, rather than paying individually for each code.*
   > *The table below identifies the composite APCs that are currently effective for services furnished on or after January 1, 2008. See Addendum A at www.cms.hhs.gov/HospitalOutpatientPPS/ for the national unadjusted payment rates for these composite APCs*.

Composite APC	Composite APC Title	Criteria for Composite Payment
8005	Computed Tomography (CT) and Computed Tomographic Angiography (CTA) without Contrast Composite	Payment for any combination of designated imaging procedures within the CT and CTA imaging family on the same date of service. **If a "without contrast" CT or CTA procedure is performed on the same date of service as a "with contrast" CT or CTA procedure, the IOCE will assign APC 8006** rather than APC 8005. For the list of imaging services included in the CT and CTA imaging family, see the I/OCE specifications document for the pertinent period.

8006	CT and CTA with Contrast Composite	

Based on the above, the carrier's reduction is supported. The fee calculation for the composite is found below.

2. 28 Texas Administrative Code §134.403 (f) states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent; unless
>
> (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

The Medicare facility specific amount is determined per guidelines found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,

> *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

Implantables are not applicable therefore, the fee is calculated per 134.403(1)(A).

Procedure Codes assigned to Composite	Composite APC	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.9572	40% non-labor related	Payment	Maximum allowable reimbursement
72125 - Computed tomography, cervical spine; without contrast material **74177** - Computed tomography, abdomen and pelvis; with contrast material(s) **70450** - Computed tomography, head or brain; without contrast	8006	$493.91	$493.91 x 60% = $296.35	$296.35 x 0.9572 = $283.67	$493.91 x 40% = $197.56	$283.67 + $197.56 = $481.23	$481.23 x 200% = $962.46

material **71260** - Computed tomography, thorax; with contrast material(s)							
						Total	$962.46

3. The total allowable reimbursement for the services in dispute is $962.46. The carrier paid $962.45. No additional reimbursement recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 29, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.